

POLICY



Indiana Comprehensive Health Insurance Association

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

ADMINISTRATOR:
P. O. BOX 33009
INDIANAPOLIS, IN 46203-0009

(called "We," "Us," "Our," "Ours," or "the Association")

TABLE OF CONTENTS

Consideration	1
Important Notice	1
Entire Contract Changes	1
Renewal Agreement	1
Policy Termination	1
Premiums	2
Policy Change	2
Insureds.....	2
Eligibility	2
Definitions.....	4
Medical Benefit Provisions	11
Pharmacy Benefit Provisions.....	18
Utilization Management Provisions.....	18
Pre-existing Conditions.....	19
Non-Allowable Expenses and Exclusions.....	19
Appeals and Grievance Procedures	22
General Provisions	24

CONSIDERATION: This Policy is issued to You by the Indiana Comprehensive Health Insurance Association (“ICHIA”) in consideration of the payment of premium and the statements in the application attached to this Policy. This Policy takes effect on the Policy Effective Date shown on the Schedule.

IMPORTANT NOTICE: **You have ten days to examine the Policy.** If You are not satisfied with it, send it back to Us within 10 business days of the date of your approval letter. We will refund any Premium You have paid. Then, it is void as if no Policy had been issued. Any request for a change to this policy must be received in writing by Us no later than 10 business days of the date your approval letter was created

Read Your Application. Be sure it is correct and complete. We rely on all statements made by or for You on the Application You signed. If anything in it is incorrect or incomplete, or if any past medical history has been left out, You should tell Us immediately. Unless corrected, Your Policy may be void and any claims denied.

ENTIRE CONTRACT CHANGES: This entire contract is the Policy, the Schedule, the Application and any Riders. No agent can change any of its terms. Only the Board of Directors of the Indiana Comprehensive Health Insurance Association can approve a change, or changes required by federal or state law. (See “Policy Change,” page 3.) Any such change must be shown in Your Policy. The contract is between the Indiana Comprehensive Health Insurance Association and the Insured shown in the Schedule (“You,” “Your” or “Insured”).

RENEWAL AGREEMENT: We will renew Your Policy each time You pay Us the premium on or before the date it is due or before the 31-day Grace Period ends, unless it is terminated as described below.

POLICY TERMINATION: **Our Right to Cancel:** This Policy will terminate on the earliest of the following:

1. the date You no longer meet the eligibility requirements;
2. the first date You are no longer a resident of Indiana;
3. the date You become eligible for Medicare; those under 65 and on Medicare due to a disability are still eligible and will not be terminated.
4. the 45th day after the date on any inquiry We make concerning Your place of residence, employment or other insurance coverage, if You have not responded to Us within that time;
5. the future date You request to end this Policy or Your paid through date;
6. the date Indiana law requires cancellation of this Policy;
7. the effective date of Your Medicaid Coverage;
8. the date You have Equivalent Coverage under another group plan.

Any premium paid for periods subsequent to the Effective Date of cancellation will be returned to You, less any non-recovered medical claim payments as well as payments made on Your behalf for prescription drugs after Your termination date. Please allow 30 calendar days from the date of Your termination request for Your refund.

PREMIUMS:

Premium Changes: Premium rates are based on the geographic area of Indiana in which You live, Your age and sex and the Plan type. Premium rates will increase as You get older and move into a different age bracket, or due to revised schedule of rates, or both. We can change premium rates only when the same change is made on all policies, with the same provisions and benefits issued to persons of the same classifications and living in the same geographic region. The Premium for this Health Benefit Plan may change annually, subject to, and as permitted by, applicable law. Notification of any Premium change will be mailed at least thirty (30) days in advance of such Premium change at the mailing address reflected in our records. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Grace Period: Thirty-one (31) days will be granted for the payment of each premium due after the first premium, during which Grace Period the Policy shall continue in force. **Claims will pend during the Grace Period.**

Late Payment: If We do not receive Your premium before the Grace Period ends, Your coverage stops at the end of the Grace Period retroactive to the last day for which the premium was received.

Reinstatement: You may appeal for reinstatement of this Policy or reapply for consideration of a future effective date of coverage under the Indiana Comprehensive Health Insurance Association if You believe you are eligible, but there is no guarantee of reinstatement.

POLICY CHANGE:

Any provision of this Policy (including a benefit reduction) is subject to change as mandated by Indiana or federal law or by the Board of Directors of ICHIA.

The Deductible and Out-of-Pocket Maximum are shown on the Schedule of Benefits. You may elect to change to a Plan that utilizes a higher Deductible. No changes are allowed to a Plan with a lower Deductible. Plan changes under this Policy are effective January 1st following the receipt of a written request which must be received in our office no later than December 1st of the prior year.

INSUREDS:

Insureds are You and / or Your Spouse and dependent children who are Insured under this Policy, as long as You meet the eligibility requirements and pay premiums.

ELIGIBILITY:

You are eligible if You are a resident of the state of Indiana, You are determined not to be eligible for Medicaid and You do not have and are not eligible for a group insurance plan that provides Equivalent Coverage. "*Resident*" means You have, for at least 12 months immediately preceding application for this Policy, resided continuously in the state of Indiana in a place of permanent habitation. You must also meet one of the eligibility categories below:

1. Federal Eligibility –You are a Federally Eligible Individual if on the date You apply for coverage You have had continuous Creditable Coverage for at least 18 months with no lapse in coverage exceeding 63 days.
2. Rejection for other health coverage – You have received notification of rejection from a health insurer for Equivalent Coverage.

Dependents: Your Spouse and unmarried children are eligible to be covered by this Policy as long as You continue to meet the eligibility requirements. You will be required to fill in Section III of the application and pay the necessary premiums for coverage to begin. Coverage for each dependent is subject to the annual deductible, coinsurance and Out-of-Pocket Maximum. If at anytime You as the primary Insured no longer meet eligibility, Your dependents must reapply and meet all eligibility requirements.

“Child” means Your:

1. child who lives with You and is Your federal income tax dependent ;
2. natural-born or legally adopted child (including a child placed with You for adoption);
3. stepchild living in Your home who is chiefly dependent on You for support; and

Newborn Children: Your newborn child is automatically covered from the moment of birth for the first 31 days after birth. Coverage for the first 31 days is subject to the annual deductible, coinsurance, and Out-of-Pocket Maximum. The coverage for newly born children consists of coverage of Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If You wish to continue the child’s coverage beyond the first 31 days and add the child as a Dependent under this Policy, You must contact Us before the end of the 31-day period to request a Dependent Application and You will be required to pay the necessary premium. If You do not add the child as a Dependent, the newborn’s coverage terminates at the end of the 31-day period after birth.

Adopted Children: The coverage for newly adopted children will be the same as for other Dependents. Coverage for an adopted child is effective upon the earlier of:

1. the date of placement for the purpose of adoption; or
2. the date of the entry of an order granting You custody of the child for purposes of adoption;

and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement for 31 days. If You wish to continue the child’s coverage beyond the first 31 days and add the adopted child as a Dependent under this Policy, You must contact Us before the end of the 31-day period to request a Dependent Application and You will be required to pay the necessary premium. If You do not add the adopted child as a Dependent, the child’s coverage terminates at the end of the 31-day period after adoption or placement for adoption.

Limiting Age: An unmarried Dependent child's coverage will terminate on the earlier of the child's 24th birthday, or the child's 25th birthday, if the child is a full-time student in an accredited high school, technical or vocational school or college or university and is chiefly dependent on You for support and maintenance.

Attainment of the limiting age will not terminate a child's coverage if the child is:

1. incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and
2. chiefly dependent upon You for support and maintenance.

Proof of such incapacity and dependency must be furnished to Us within 120 days of the child's attainment of the limiting age, and subsequently as We require, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination: A Dependent's insurance will end on the earliest of the date:

1. any Dependent's premium is due and unpaid at the end of the Grace Period;
2. the first date on which a Dependent is no longer a resident of Indiana or is no longer eligible;
3. the Dependent becomes eligible for Medicare; those under 65 and on Medicare due to a disability are still eligible and will not be terminated.
4. the date You are determined to be eligible for Medicaid.
5. Your insurance terminates, except as provided below.

Continuation: Upon Your death, Your Spouse and Dependents may elect, within 31 days after the date of death, to continue coverage under this Policy. The surviving Spouse or Dependents will need to complete a new ICHIA application and meet the ICHIA eligibility requirements to maintain the coverage.

DEFINITIONS:

ADMINISTRATOR: Us, unless We contract with another party to perform administrative services on Our behalf. In that case, the other party is the Administrator.

ALLOWED CHARGE: A charge for a service or supply that is based on Our prevailing health care charges data. This data reflects a current statistical sampling of charges for services and supplies made in the same or comparable area.

In the event of multiple surgeries or multiple surgeons in attendance during one operation, or for services or supplies for which data is unavailable, ALLOWED CHARGE will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned.

ALLOWABLE EXPENSES: Those charges for Health Care Services and supplies provided for by ICHIA, and charges based upon Our Covered Services determination for Medically Necessary Allowable Services.

ASSOCIATION: The Indiana Comprehensive Health Insurance Association.

ASSOCIATION POLICY: A Policy issued by the Association that provides coverage specified by Indiana law.

CALENDAR YEAR: January 1 through December 31 of the same year. The first Calendar Year begins on the Policy Effective Date and ends on December 31 of the same year.

CARRIER: An insurer providing medical, hospital or surgical expense incurred Health Insurance policies.

CHURCH PLAN: A plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 USC 414(e).

COMMISSIONER: The Insurance Commissioner of the State of Indiana.

CREDITABLE COVERAGE: As defined in the federal Health Insurance Portability and Accountability Act of 1996 (26 USC 9801(c)(1)). Creditable Coverage is prior coverage You had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, public health plan, Peace Corps Service or an individual health plan, as set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 USC 9801 (c)(1)).

CUSTODIAL CARE: Services or treatment which, regardless of where it is provided, could be rendered safely by a person without medical skills, and is designed mainly to help the patient with daily living activities, including but not limited to:

1. personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema and using the toilet;
2. homemaking, such as preparing meals or special diets;
3. moving the patient;
4. acting as a companion or sitter;
5. supervising medication which can usually be self-administered;
6. oral hygiene; and
7. ordinary skin and nail care.

Our medical staff and / or an independent medical review panel determine what services are Custodial Care. When a confinement or visit is found to be mainly for Custodial Care, some services (such as prescription drugs, X-rays and lab tests) may still be covered. All bills should be routinely submitted for consideration.

DENTAL OR DENTAL SERVICES: Health Care Services provided for the diagnosis, prevention and treatment of oral malformations, and any disease affecting the teeth and their related structures.

DISEASE MANAGEMENT: A system of coordinated health care interventions and communications for populations with chronic conditions. It involves significant patient self-care efforts. (Source: Disease Management Association of America.) Participation in a Disease Management Program is

mandatory for those with a diagnosis or condition for which Disease Management is available. In the event a Participant has a diagnosed disease condition for which ICHIA has a disease management program, the Participant **MUST** become involved in that program. In the event a Participant refuses to be involved in that program, a written notice will be sent to the last known address of the Participant requiring their involvement. The person will be notified that unless and until they become involved in the disease management program and compliant with its requirements, ICHIA will not pay for the services and treatments associated with that particular disease condition. ICHIA will pay for all other Covered Benefits, but not those associated with the particular disease condition.

EQUIVALENT COVERAGE: Coverage under any insurance plan that equals or exceeds the minimum requirement for accident and sickness insurance policies issued in Indiana.

EXPERIMENTAL: The use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring federal or other government agency approval not granted at the time services were provided. The final determination as to whether one of the above items is Experimental will be made by Our designated Medical Policy Committee.

FAMILY: You and Your Spouse and Your Dependent children who are Insured under this Policy.

FEDERALLY ELIGIBLE INDIVIDUAL: An individual:

1. for whom, as of the date on which the individual seeks coverage through ICHIA, the aggregate period of Creditable Coverage is at least 18 months and whose most recent prior Creditable Coverage was under a:
 - a) Group Health Plan;
 - b) Governmental Plan; or
 - c) Church Plan;or Equivalent Coverage in connection with any of these plans;
2. who is not eligible for coverage under:
 - a) a Group Health Plan;
 - b) a state plan under Title XIX of the federal Social Security Act (or any successor program); and does not have other Equivalent Coverage;
 - c) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
 - d) Chapter 55 of title 10, United States Code;
 - e) a medical care program of the Indiana Health Service or of a tribal organization;
 - f) a State health benefits risk pool;
 - g) a health plan offered under chapter 89 of title 5, United States Code;
 - h) a public health plan (as defined in regulations);
 - j) A health benefit plan under section 5(e) of the Peace Corps Act (22 USC 2504(e)).

3. with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;
4. who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and
5. who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

GOVERNMENTAL PLAN: A plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

GROUP HEALTH PLAN: An employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides Medical Care Payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise.

HEALTH CARE FACILITY: Any institution providing Health Care Services that is licensed in the State of Indiana, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, Injury, deformity, physical or mental condition, including a general Hospital, special Hospital, psychiatric Hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis Hospital, chronic disease Hospital, maternity Hospital, Outpatient clinic, Home Health Care Agency, bioanalytical laboratory or central services facility servicing one or more such institutions.

HEALTH CARE INSTITUTIONS: Skilled nursing facilities, home health agencies and Hospitals.

HEALTH CARE PROVIDER: Any Physician, Hospital, pharmacist or other person who is licensed in Indiana to furnish Health Care Services.

HEALTH CARE SERVICES: Any services or products provided to any individual of medical care, mental health / psychiatric care, Dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as those provided to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human Illness or Injury that are Covered Benefits under Their Plan.

HEALTH INSURANCE: Hospital, surgical and medical expense incurred policies, non-profit service plan contracts, health maintenance organizations, limited service health maintenance organizations and self-Insured plans. However, the term "Health Insurance" does not include short-term travel accident policies, accident only policies, fixed indemnity policies, automobile medical payment or incidental coverage issued with or as a supplement to liability insurance.

HOME HEALTH CARE AGENCY: A public or private agency or organization licensed and operated in accordance with state law that provides medical care to patients in their home.

HOME HEALTH CARE PLAN: Continued care and treatment of an Insured who is under the care of a Physician, and who would need Hospital or Skilled Nursing Facility confinement without the home health care. The Home Health Care Plan must be submitted to the Administrator for approval in writing by the attending Physician.

HOSPITAL. Any of the following places:

1. a place which is licensed or recognized as a general Hospital by the proper authority of the state in which it is located;
2. a place which is operated for the care and treatment of resident Inpatients, has a registered graduate nurse (RN) always on duty, has a laboratory and X-ray facility, and has a place where major surgical operations are performed; or
3. a place recognized as a general Hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

When treatment is needed for a mental disease or disorder, Hospital can also mean a place that meets these requirements:

1. has rooms for resident Inpatients;
2. is equipped to treat mental diseases or disorders;
3. has a resident psychiatrist on duty or on call at all times; and
4. as a regular practice, charges the patient for the expense of confinement.

A Hospital does not include a Hospital or institution or part of a Hospital or institution which is licensed or used principally as a clinic, Skilled Nursing Care Facility, convalescent home, rest home, nursing home or home for the aged.

ILLNESS: A disease, disorder or condition which requires treatment by a Physician.

INDIVIDUAL PLAN: Health coverage on an individual basis, not part of a group. The premium is usually higher for individual health insurance than for a group policy.

INJURY: Accidental bodily Injury that requires treatment by a Physician.

IN NETWORK PROVIDER, [PPO] PROVIDER: Network Provider means any Provider which has agreed to participate in the Blue Access Program. Network providers file claims for their services and claims are paid directly to them. They have agreed not to bill you except for the amount of Deductible, Coinsurance and charges incurred for non-covered services. For the most current list of in-network providers visit www.ichia.org which has a link to the Blue Access Network. The list of Physicians and their ability to accept new patients is subject to change. You may elect to use Out-of-network Providers, out-of-network means any Provider which has not agreed to participate in the Blue Access Program. Out-of-network Providers may bill you for the balance

of their charges in excess of the Eligible Expense, in addition to any Deductible, Coinsurance and charges for non-covered services.

INPATIENT: An Insured who is treated as an Inpatient in a Hospital and for whom a room and board charge is made.

INSURED: You and / or Your Spouse and Dependent children who are Insured under this Policy.

INSURED PERSON: The person in whose name this Policy was issued, named on the Schedule.

MEDICAID: Medical assistance provided by the state under the Medicaid program under Indiana Code 12-15.

MEDICAL CARE PAYMENT: Amounts paid for:

1. the diagnosis, care, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;
2. transportation primarily for and essential to receive Medically Necessary services; and
3. insurance covering medical care referred to in subdivisions (1) and (2).

MEDICALLY NECESSARY OR MEDICAL NECESSITY: Services or supplies received for the treatment of an Illness or Injury or other health condition that is determined by Us to be:

1. appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards;
2. not primarily Custodial in nature;
3. not Experimental or unproven;
4. not excessive in scope, duration or intensity to provide safe, adequate and appropriate treatment, and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the Outpatient department of a Hospital, without adversely affecting the patient's condition; and
5. not provided only as a convenience to You, Your Physician or another Provider or person.

Your physician may prescribe, order, recommend, or approve services or a particular level of care. This, in itself, does not make the treatment or service Medically Necessary, thus payable. Should You choose to proceed with Your physician's recommendation and ICHIA does not recognize the service or treatment as Medically Necessary, You will be held responsible for all related costs.

Any service or supply provided at a Health Care Facility will not be considered Medically Necessary, if Your symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

MEDICARE: Health Care Service under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

MENTAL ILLNESS INCLUDING SUBSTANCE ABUSE:

1. Mental Illness is a clinically significant behavioral or psychological disorder marked by a pronounced deviation from a normal healthy state and associated with a present painful symptom or impairment in one or more important areas of functioning. This disease must not be merely an expectable response to a particular stimulus.
2. Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his / her health is impaired and / or ability to control actions is lost.

MONTHLY EFFECTIVE DATE: The day each month Your Premium payments are due. If You pay more than one month at a time, it also means the same day of each month in between payments.

OUT-OF-NETWORK PROVIDER: A Provider who has not signed an agreement with the PPO.

OUTPATIENT: A person who is a patient other than a bed patient at a Hospital's Outpatient department or other Health Care Facility.

PHYSICIAN: Any of the following who is operating within the scope of his or her license: Doctor of Medicine (MD); a Doctor of Osteopathy (DO); a licensed dentist, podiatrist, optometrist or chiropractor; a licensed Psychologist.

POLICY: A contract, Policy or plan of Health Insurance.

POLICY YEAR: A 12-month calendar year period during which a Policy provides coverage or obligates the Carrier to provide Health Care Services.

PRE-EXISTING CONDITION: Any condition or Illness that existed on or before the Effective Date of coverage, and for which medical treatment or advice was recommended or received within a period of three months before the Effective Date of coverage.

PREFERRED PROVIDER ORGANIZATION (PPO): A network of Physicians and Hospitals who have entered into an agreement to accept discounted fees for services provided under this Policy. Your share of Coinsurance is reduced when You use a PPO, and PPO Providers will submit claims directly to ICHIA for You.

RECIPROCITY: Means that if an individual has been enrolled under a similar state plan, has met the pre-existing waiting period and has not used up the entire lifetime maximum, he or she is eligible to apply in another state after meeting the residency requirement. If application is made within a certain period of time, no other requirements (such as proof of rejection or waiting period) are required. Under HIPAA, previous coverage by a state risk pool qualifies as continuous creditable coverage.

SERVICES OF A SKILLED NURSING FACILITY: Services that must commence within 14 days following a confinement of at least three consecutive days in a Hospital for the same condition.

SKILLED NURSING FACILITY: An institution or that part of an institution which provides convalescent or nursing care and is or could be certified as a Skilled Nursing Care Facility under Medicare.

SPOUSE: The person recognized as Your husband or wife under Indiana law.

THERAPY SERVICES: Services and supplies used to promote recovery from an Illness or Injury. Covered Therapy Services are limited to those specifically listed in the Allowable Services.

UTILIZATION MANAGEMENT: A program We administer as part of this Policy to ensure that the care You receive is Medically Necessary and cost-effective, and that the type of care You receive is appropriate. The Utilization Management Program is administered by registered nurses and board certified Physicians and includes case management, disease management, pre-certification services, and such other programs may be implemented.

WE, US, OR OUR: The Indiana Comprehensive Health Insurance Association.

YOU OR YOUR: The Insured Person named on the Schedule and Policy.

MEDICAL BENEFIT PROVISIONS:

BENEFIT PAYMENT: You will pay the Coinsurance amount shown in the Schedule after any Deductibles shown in the Schedule have been met for Allowable Expenses incurred by an Insured for an Injury or Illness in each Calendar Year. The benefits payable are subject to all the terms, conditions, limitations and exclusions listed in the Policy, as well as the Benefit Maximums shown on the Schedule.

PAYMENT LEVELS: Your Policy includes a Preferred Provider Organization (PPO) Plan. The payment level for Allowable Expenses is dependent upon the Provider selected. If an Insured receives services from a Provider who is contracted with the Preferred Provider Organization, the payment level will be at the PPO Coinsurance percentage shown in the Schedule, subject to the Deductible and any applicable Copayments. **See the Utilization Management Provision for more information on the PPO plan.**

DEDUCTIBLE: The amount of Allowable Expenses that must be incurred and paid by the Insured in a Calendar Year before benefits become payable by Us. The first Calendar Year begins on the Effective Date of the Policy and ends on December 31 of that same year.

No more than one Deductible must be satisfied by each Insured during a Calendar Year.

You may elect to change to a Plan with a higher Deductible. No changes are allowed to a Plan with a lower Deductible Plan changes under this Policy are effective January 1st following receipt of a written request which must be received by our office December 1st of the prior year.

COINSURANCE: Coinsurance is the percentage of Allowable Expenses You pay after the Deductible has been satisfied. The Coinsurance percentage is shown in the Schedule.

OUT-OF-POCKET MAXIMUM: The Out-of-Pocket Maximum represents the total dollar amount, including the Deductible and Coinsurance that an Insured will have to pay toward Allowable Expenses in a Calendar Year.

When the Individual Out-of-Pocket Maximum is reached in each Calendar Year, We will pay 100% for additional Allowable Expenses incurred by that Insured, up to the benefit maximums listed in the Schedule, for the remainder of that Calendar Year.

The benefits, deductible, copays and additional amounts for which You may be responsible for pharmacy related benefits are specifically set out in the Schedule for the Plan You have selected.

Computation of the Out-of-Pocket Maximum does not include: Non-Eligible Benefits, Non-allowable Expenses, out-of-network or precertification penalties and pharmacy benefits.

The Individual and Family Out-of-Pocket Maximums are shown on the Schedule enclosed.

ALLOWABLE SERVICES: We will pay the Allowable Charge for Medically Necessary Allowable Health Care Services covered under Your Plan and rendered or furnished for the diagnosis or treatment of Illness or Injury that exceed the Deductible and Coinsurance amounts under Your Policy.

Allowable Expenses are the charges for the following Health Care Services and articles to the extent furnished by a medically necessary Health Care Provider in an emergency situation or furnished or prescribed by a Physician:

SCHEDULE OF BENEFITS:

1. **Hospital Services:** Includes charges for the Institution's most common semi-private room and for private room only when Medically Necessary. Read your Schedule of Benefits for the actual number of days covered per calendar year.
2. **Outpatient Services:** Includes charges provided during Outpatient treatment at a Hospital, an ambulatory surgical facility or freestanding dialysis facility.
3. **Professional Services:** For the diagnosis or treatment of injuries, illnesses or conditions, other than Mental or Dental, that are rendered by a Physician or, at the Physician's direction, by the Physician's staff of registered or licensed nurses and allied health professionals.
4. **Mental Illness including Substance Abuse Conditions:** See the Schedule of Benefits for limits.
5. **Skilled Nursing Facility:** For not more than 180 days in a Calendar Year and for services that begin within 14 days following a confinement of at least three consecutive days in a Hospital for the same condition.
6. **Home Health Agency:** Up to 270 visits (up to eight hours equals one visit) of service in a Calendar Year. Home Health Care Services are the services and supplies rendered to a "home bound" Insured which are medically necessary, ordered and directed by a Physician and furnished:
 - a) in the Insured's private home;
 - b) by a Home Health Agency;
 - c) in accord with a Home Health Plan; and
 - d) with prior approval by Our medical review committee.

Coverage includes:

- a) nursing care provided at home on a part-time basis (up to 8-hours equals 1 day) by an RN or a licensed practical nurse (LPN);
- b) therapy provided by a Physical Therapist, Occupational Therapist, Inhalation / Respiratory Therapist or Speech Therapist;
- c) Medically Necessary services and supplies required for administration of a home infusion therapy regimen when ordered by a Physician and provided by a home infusion therapy Provider and certified in advance by Us.

Home infusion therapy is limited to:

- chemotherapy.
- intravenous antibiotic therapy.
- total parenteral nutrition.
- enteral nutrition (when sole source of nutrition).
- hydration therapy.
- intravenous pain management.

Coverage will be provided only for the following Medically Necessary services and supplies:

- solution and pharmaceutical additives.
- pharmacy compounding and dispensing services.
- Durable Medical Equipment. (There may be limitations.)
- ancillary medical supplies.
- nursing services associated with:
 - patient and / or alternative caregiver training.
 - visits necessary to monitor intravenous therapy regimen.
 - emergency care.
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

9. **Hospice:** Hospice Services are covered when the insured has been certified by a Physician to be terminally ill, with a life expectancy of six (6) months or less and elects Hospice coverage in lieu of continued attempts at cure. Hospice includes services, supplies and care to help provide comfort and relief from pain.
10. **Chemotherapy and Radiation Therapy:** Services include the use of chemotherapy and radiation therapy to treat Injury or Illness.
11. **Oxygen:** As needed and when Medically Necessary.
12. **Anesthetics:** Anesthesia when it is Medically Necessary that the service be performed by a Physician other than the surgeon or assistant surgeon.
13. **Prosthetic Appliances:** Purchase, fitting, needed adjustment, repairs and replacements of prosthetic devices and supplies that:
 - a) replace all or part of a missing body part and its adjoining tissues;
 - b) replace all or part of the function of a permanently useless or malfunctioning body part.

Benefits for prosthetic appliances include:

- a) lens(es) implanted during cataract surgery
- b) breast prostheses and two surgical brassieres each Benefit Period following a mastectomy.

Non-covered items include but are not limited to Dental prosthesis, eyeglasses or contact lenses or their fitting, except as provided above.

14. **Orthotic Devices:** A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part.

15. **Rental of Durable Medical Equipment:** Equipment that has no personal use in the absence of the condition for which it is prescribed shall not be considered medically necessary. There are limitations. We will pay for rental (up to the purchase price) when:

- a) approved by Us in advance;
- b) prescribed by the attending Physician;
- c) the equipment will reduce or eliminate the time required for Hospital or Skilled Nursing Facility confinement, is useful only to the Insured and not to any person in the absence of Illness or Injury, and is used to serve a medical purpose rather than for transportation, comfort or convenience.

16. **Diagnostic X-rays and Laboratory Tests** as Medically Necessary.

17. **Oral surgery** for:

- a) excision of partially or completely erupted impacted teeth;
- b) excision of a tooth root without the extraction of the entire tooth; or
- c) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth; and
- d) Anesthesia in connection with any covered service.

18. **Therapies**

- a) Physical therapy including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore or maintain function and to prevent disability following Illness, Injury or loss of a body part.
- b) Speech therapy for the correction of a speech impairment resulting from Illness, Injury or surgery. Speech therapy does not include language training for educational, psychological or developmental speech delays.
- c) Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).
- d) Spinal manipulation services to correct, by manual or mechanical means, structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column.

Other Therapy Services:

- a) Cardiac rehabilitation to restore an individual's functional status after a cardiac event. Home programs, ongoing conditioning and maintenance are not covered.
- b) Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents.
- c) Dialysis treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- d) Radiation therapy for the treatment of disease by x-ray, radium or radioactive isotopes.

- e) Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.
19. **Professional Ambulance:** Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
- a) From a Covered Person's home or scene of accident or medical emergency to closest facility that can provide Covered Services appropriate to the Covered Person's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Covered Persons condition, ambulance service means transportation to the closest facility outside the local area that can provide the necessary services;
 - b) Between Hospitals; and
 - c) Between a Hospital and Nursing Facility.
20. Other Medically Necessary **Medical Supplies** for which a Physician's order is required.
21. **Pregnancy:** Covered the same as any other medical condition. Coverage for the Inpatient postpartum stay for You and Your newborn child in a Hospital will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if Your attending Physician determines further Inpatient postpartum care is not necessary for You or Your newborn child, provided the following are met:

- a) In the opinion of Your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 - the antepartum, intrapartum and postpartum course of the mother and infant;
 - the gestational stage, birth weight and clinical condition of the infant;
 - the demonstrated ability of the mother to care for the infant after discharge; and
 - the availability of post discharge follow-up to verify the condition of the infant after discharge.
- b) **One (1) at-home post delivery care visit** is provided to You at Your residence by a Physician or Nurse performed no later than 48 hours following Your and Your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:
 - parent education;
 - assistance and training in breast or bottle feeding; and
 - performance of any maternal or neonatal tests routinely

performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At Your discretion, this visit may occur at the Physician's office.

- c) In addition, coverage is provided for an examination given at the earliest feasible time to Your newborn child for the detection of the following disorders:
- Phenylketonuria;
 - Hypothyroidism;
 - Hemoglobinopathies, including sickle cell anemia;
 - Galactosemia;
 - Maple Syrup urine disease;
 - Homocystinuria;
 - Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
 - Physiologic hearing screening examination for the detection of hearing impairments;
 - Congenital adrenal hyperplasia;
 - Biotinidase deficiency;
 - Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

22. Transplant Surgery Benefits: Eligible Expenses include charges incurred by the recipient for Covered Services that are directly related to or result from the completion of a covered transplant procedure, including all pre-operative and post-operative services; Eligible Expenses also include charges which are directly related to the surgical, storage and transportation costs incurred in the donation of an organ for a covered transplant procedure. Reasonable and necessary transportation if the transplant is to be performed more than 75 miles from the patient's home.

Meals and lodging expenses are covered to and from the site of the covered transplant procedure and while at the site of the covered transplant procedure for the Member and companion within reasonable limits determined by the Plan (See preauthorization requirements). If the patient is a minor, expenses for transportation, meals and lodging will be covered for two (2) companions. Non-Eligible Expenses include services before the effective date of coverage under this Plan or after the termination date of coverage. In addition to the exclusions applicable under the Plan, benefits will not be provided for covered expenses related to the transplant of any non human organ or tissue; or which are repaid under any private or public research fund; expenses incurred by a living donor for transportation, meals or lodging

- a) We will pay the Insured's Allowable Expenses in the same manner as any other illness;
- b) If the donor requires surgery to make an organ available after benefits are paid for the Insured's Allowable Expenses, We will pay the donor's Allowable Expenses as if the expense was incurred by an Insured.

We will not pay for any financial consideration to the donor other than for a covered expense that is incurred in the performance of or in relation to transplant surgery. **Transplant surgery benefits will be payable only if the surgery is approved by Us in advance.**

Transplant benefits are not payable for any expense or charge for services or supplies that are:

- a) not provided in accordance with generally accepted medical standards;
- b) Experimental;
- c) Investigative and not proven safe and effective.

23. Blue Distinction Centers for Transplant: The Blue Distinction Centers for Transplant (BDCT) is a program of the Blue Cross and Blue Shield Association that brings together transplant expertise among physicians and hospitals for the benefit of ICHIA members utilizing Anthem Provider Networks. BDCT consists of a national network of transplant centers that offer comprehensive services coordinated through streamlined referral management. All of the centers in the BDCT network meet specific participation criteria that consider not only provider qualifications and programs, but patient outcomes as well. These centers provide transplant services at favorable rates.

24. Coverage for Services Related to Breast Cancer Screening: "Breast cancer screening mammography" means a standard, two (2) view per breast, low-dose radiographic examination of the breasts that is:
(1) furnished to an asymptomatic woman; and
(2) performed by a mammography services provider using equipment designed by the manufacturer for and dedicated specifically to mammography in order to detect unsuspected breast cancer.

The term includes the interpretation of the results of a breast cancer screening mammography by a physician. "Woman at risk" means a woman who meets at least one (1) of the following descriptions:

A woman who has a personal history of breast cancer.

A woman who has a personal history of breast disease that was proven benign by biopsy.

A woman whose mother, sister or daughter has had breast cancer.

A woman who is at least thirty (30) years of age and has not given birth.

If the insured is at least thirty-five (35) but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon the insured before she becomes forty (40) years of age.

If the insured is:

less than forty (40) years of age; and

a woman at risk;

one (1) breast cancer screening mammography performed upon the insured every year.

If the insured is at least forty (40) years of age, one (1) breast cancer screening mammography performed upon the insured

every year.

Any additional mammography views that are required for proper evaluation.

Ultrasound services, if determined medically necessary by the physician treating the insured.

PHARMACY BENEFIT PROVISIONS:

1. **Drugs and Contraceptive Devices:** Prescription Drug coverage is limited to injectable insulin, including syringes and diabetic supplies, contraceptives for which a prescription is required, and drugs that under federal law may only be dispensed by written prescription, which are approved for general use for treatment of a given condition by the Food and Drug Administration, and which are adopted by the Plan. The drugs must be dispensed by a licensed Pharmacy Provider during the period a Covered Person is an Outpatient and is eligible to receive benefits under the Plan. Benefits for covered Prescription Drugs are limited to quantities which can reasonably be expected to be consumed or used within one (1) month, or as otherwise authorized by the Plan.
2. **Mail Service Pharmacy:** Mail Service Pharmacy is intended for refills of maintenance medications where a stable dosage has been determined. For this reason, Anthem Prescription generally recommends that the initial order for any maintenance medicine be filled through a retail Pharmacy in case the dosage needs to be adjusted. Once the correct dosage is established, the Mail Service Pharmacy is an appropriate cost saving choice. ICHIA offers Members four convenient options for ordering prescription refills through Anthem Rx. By mail, Members simply complete and return the refill envelope included with each previously filled prescription order. By phone, Members call Anthem Rx Customer Care at 1.800.962.8192, Monday through Friday, 9:00 A.M. to 11:00 P.M. Eastern time or Saturday, 9:00 A.M. to 5:00 P.M. Visa, MasterCard or Discover cards are accepted on telephone refill orders. By an automated telephone line, Members with existing Anthem Rx accounts can place refill orders twenty four (24) hours a day once their credit card number is entered into the Anthem Rx system. They simply select the "automated voice response unit" selection at 1.800.962.8192. They are then prompted to enter their prescription number(s) and credit card information to complete the order using their telephone keypad. Via APM's website, link from www.ichia.org.

UTILIZATION MANAGEMENT PROVISIONS:

PREFERRED PROVIDER ORGANIZATION:

When services are provided by the following types of Providers, Your Coinsurance liability is as follows until You reach the Out-of-Pocket Maximum under Your Plan:

In-Network PPO Provider:	20% of the Allowable Expense
Out of Network Provider:	40% of the Allowable Expense

No amount in excess of the reimbursement percentage charge shown above will be an Allowable Expense under this Policy. These amounts do not apply to the Out-of-Pocket Maximum.

The PPO limits above do not apply to the following:

1. Emergency accident or Illness. Emergency accident means the initial treatment provided by a Hospital or Physician for traumatic bodily Injury resulting from an accident when such treatment is received within 72 hours of this accident. Emergency Illness means the initial treatment provided by a Hospital or Physician for a condition that is not accident-related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in: permanently jeopardizing health; other serious medical consequences; serious impairment of bodily function or serious and permanent dysfunction of any body organ or part.
2. Any maternity benefits, if conception occurred before the Policy Effective Date.
3. Any Medically Necessary care that is not available from a [PPO] Provider within a 30 mile radius of the member's home.

PRECERTIFICATION: Precertification does NOT guarantee coverage for, or the payment of, the service or procedure reviewed. Precertification is a process that requires that an approval be obtained from Us for All Inpatient Admissions (Medical, Surgical, Behavioral Health and Chemical Dependency), Inpatient Rehabilitation, Skilled Nursing Facility, Hospice, Transplants, Chemotherapy, DME when purchase prices exceeds \$500.00, Home Health Care, Therapy Services (Speech, Occupational, Physical and Chiropractic, Treatment of Pervasive Developmental Disorders, Bariatric Surgery (regardless of setting), Spinal (Back) Surgery (regardless of setting), Blepharoplasty, Abdominoplasty, Lipectomy, Breast Reconstruction/Breast Enlargement, Breast Reduction/Mammoplasty, Sclerotherapy or surgery for varicose veins, Any other potentially cosmetic procedure, Orthognathic Surgery or Surgical Management of the Temporomandibular Joint, MRI/MRA, PET Scans, Prosthetics/Orthotics and any service that may be considered investigational or experimental.

While many Physicians will handle the precertification, it is ultimately Your responsibility to ensure precertification has been made. When care is evaluated, both Medical Necessity and appropriate length of stay will be determined. Medical Necessity includes a review of both the service and the setting. When approved, a copy of the approval will be provided to You, the Physician, and the Hospital or facility. The care will be covered according to Your benefits for the number of days approved unless Our concurrent review determines that the number of days should be revised.

To obtain precertification approval, call the phone number shown on Your Identification Card and Schedule. Permission approval must be obtained at least seven business days before a planned admission and within 48 hours after a maternity or emergency admission on a week day, or within 72 hours after a weekend or legal holiday admission, or as soon as reasonably possible after that. Skilled Nursing Facility admissions must be precertified within 24 hours prior to the scheduled transfer from a Hospital.

Benefits for services rendered to you as an inpatient or any service provided that requires precertification which were rendered on the days that were not approved by Us or which were not precertified by us, will be denied.

Failure to Obtain Precertification: If Precertification is not obtained as described above, Your benefits will be reduced as shown on the Schedule in Your Plan guide.

PLAN 1, Plan 1 Rx and 4: ELECTIVE SECOND SURGICAL OPINION. We will pay 100% of the Allowed Charge amount for second surgical opinions and connected laboratory and x-ray services, if the opinion is given by a specialist who:

1. is certified by the American Board of Medical Specialties in a field related to the proposed surgery, or if such a specialist is not available, a specialist referred by Us;
2. is independent of the Physician who first advised for or against the surgery and does not perform the surgery;
3. makes a personal exam of the Insured; and
4. the specialist sends ICHIA a written report.

**PRE-EXISTING
CONDITIONS:**

This Policy does not pay benefits for the first three months following the Effective Date for any Pre-existing Condition. This Pre-existing Condition limit does not apply to Federally Eligible Individuals and to individuals who meet the requirements for a waiver of the Pre-existing Condition provision.

**NON-ALLOWABLE
EXPENSES AND
EXCLUSIONS:**

No benefits are payable under the Policy for any of the following:

1. Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.
2. Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States, unless otherwise required by law. ICHIA will coordinate benefits where other coverage is primary.
3. Benefits that would duplicate the provision of services or payment of charges for any care for Injury or disease either:
 - a) arising out of, and in the course of, an employment subject to a Worker's Compensation or similar law; or
 - b) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance Policy or equivalent self-insurance.

This does not exclude charges that exceed the benefits payable under the applicable Worker's Compensation or no-fault coverage.

4. Care which is primarily for a Custodial or domiciliary purpose.

5. Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.
6. Elective abortions; sterilization or reversal of sterilization; family planning counseling.
7. Artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of infertility.
8. Dental services including prosthetics.
9. Any kind of private duty nursing care except as described in the Home Health Care Plan.
10. Care or supplies that are not Medically Necessary, that are Experimental or are not recommended by a Physician.
11. Cosmetic care or surgery and related supplies, except that We will cover services:
 - a) required as a result of an Injury received while Insured under this Policy;
 - b) for repair of congenital defects of newborn children and birth defects if the Insured is under age 12 or if he / she was under age 12 when first surgically treated for that condition;
 - c) for otherwise covered medical expenses that are an integral part of such surgery;
 - d) required as a result of previous Medically Necessary surgery if the Insured had uninterrupted coverage with Us from the date of the previous surgery.
12. Services provided by a Skilled Nursing Facility, Home Health Agency or Hospital that does not meet the definitions of such facilities in this Policy.
13. Charges Medicaid or Medicare paid, or for which Medicaid or Medicare would have been liable for, if the Insured had enrolled in those programs.
14. Care or supplies received from a Dental or medical department run by an employer, mutual benefit association, labor union, trust or similar person or group to the extent You have no obligation to pay for them.
15. Expenses incurred before an Insured's coverage starts or after it ends.
16. Benefits for the first three months following the Effective Date for any Pre-existing Condition, unless You are a Federally Eligible Individual or qualify for a waiver.
17. Any expense in excess of the Allowed Charge.
18. Expense or charge which results, whether the Insured is sane or insane, from an intentionally self-inflicted Injury or Illness or suicide or attempted

suicide.

19. Obesity Weight reduction programs or treatment for obesity (except for surgery for morbid obesity where the condition has developed to be of a life-threatening nature to the Covered Person and documentation exists of a physician supervised weight loss program in duration of at least 3-6 months and within the previous 12-18 months) and any surgery for the removal of excess fat or skin following weight loss due to obesity, surgery or pregnancy, regardless of Medical Necessity, or services at a health spa or similar facility. Services, supplies or other care for gastric / bubble / gastric balloon procedures. additional examples of excluded services are stomach stapling, wiring of the jaw, liposuction, dietary supplements, diet pills and appetite suppressants and jejunal bypasses. "Morbid obesity" means.
 - a) a weight of at least two times the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
 - b) a body mass index of at least 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or
 - c) a body mass index of at least 40 kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

20. Orthopedic shoes, Orthotics or other support devices for the feet except for insured's with Diabetes.
21. Treatment of craniomandibular or temporomandibular joint (TMJ) disorders.
22. Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning.
23. Services or supplies which are chiefly for instruction, education or training, except for diabetes educational training.
24. Acupuncture treatment (except when used as an anesthetic agent for a covered surgery).
25. Charges for services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the **illness** shall be a **covered expense**.
26. Charges for family therapy.
27. Charges for marital counseling.
28. Charges for biofeedback therapy.
29. Charges for expenses related to hypnosis.

30. Charges for Massage Therapy
31. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness. This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy or surgery. Under these conditions, purchase of a wig or artificial hair piece is limited to one per lifetime.
32. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
33. Injury or Illness to the extent payable under automobile no-fault coverage.
34. Services provided by a person who lives in the Insured's home or who is a member of Your Family or the Family of Your Spouse.
35. Eyeglasses, (except for the first lens(es) following cataract surgery), contact lenses, hearing aids or their fittings.
36. Smoking Cessation services or treatment.
37. Routine or preventive care services, unless specifically stated as covered.
38. Prescription medications for weight loss, smoking deterrents, fluoride preparations, topical minoxidil, products which do not require a prescription even if ordered by your physician, products which are not federal legend even if the state in which you reside requires a prescription, experimental drugs, refills of covered drugs which exceed the number of refills the prescription order calls for, or refills after one year from the original prescription date.

**APPEALS AND
GRIEVANCE
PROCEDURES:**

Appeal

1. Appeal means any dissatisfaction expressed orally or in writing by or on behalf of an enrollee of ICHIA no later than 60 days of the Administrators decision regarding:
 - a) the availability, delivery, appropriateness or quality of Health Care Services;
 - b) the handling or payment of claims for Health Care Services; or
 - c) matters pertaining to the contractual relationship between an enrollee and ICHIA; and for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.
2. The appeals procedure begins when an enrollee or his / her representative contacts the Administrator at the address or phone number below and makes an appeal.

3. The following steps will be taken upon receipt by ICHIA of an appeal:
 - a) The Administrator will document receipt of the appeal, including the date received, nature of the complaint and ultimate resolution.
 - b) The Administrator will investigate and resolve the appeal in an expeditious manner. The Administrator will notify the enrollee or his / her representative by mail of the disposition of the appeal.
 - c) If the appeal is denied in whole or in part, the enrollee will be notified of the right to appeal the decision of the Administrator.

Grievance Procedures

1. The grievance procedure begins when an enrollee or his or her representative sends written notification to the Administrator at the address below requesting review of the Administrator's appeal decision.
2. The written notification must be mailed within 60 days from the date on the letter notifying the enrollee of the right to file a grievance. The enrollee or his / her representative may include an explanation of the reason(s) why the decision should be different.
3. The Administrator will mail written acknowledgement of the grievance to the enrollee or his / her representative within five business days after the grievance is received.
4. The acknowledgement will include the date the grievance was received and the name, address and telephone number of an individual to contact regarding the grievance.
5. ICHIA will appoint a Grievance Committee composed of individuals who have sufficient experience, knowledge and training to appropriately resolve a grievance.
6. An enrollee or a representative wishing to appear before the Grievance Committee in person to present the appeal may do so by contacting the Administrator at the address provided in the notice to the enrollee of the right to file a grievance on the appeal decision.
7. The Grievance Committee will investigate and resolve the grievance in an expeditious manner.
8. The enrollee will be notified by mail of the resolution of the grievance not more than the earlier of:
 - a) 45 days after the grievance is filed; or
 - b) five business days after completion of the investigation.
9. Written notification of the resolution of the grievance will include:
 - a) a statement of the Grievance Committee's understanding of the enrollee's grievance;
 - b) a description of the resolution reached by the Grievance Committee and the contract basis or medical rationale for the resolution, stated in clear terms;
 - c) a reference to the evidence or documentation used as a basis for the resolution;
 - d) a notice of the enrollee's right to further remedies allowed by law; and

- e) the department, address and telephone number through which an enrollee may contact a qualified representative to obtain more information about the resolution of the grievance.

External Review

You or Your representative has the right to file a written request with ICHIA for an external grievance review of Your appeal resolution under Indiana law (IC 27-8-28-17). You must submit Your request not more than forty-five (45) days after You are notified of the resolution. This right includes an **expedited** external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize Your life or health; or Your ability to reach and maintain maximum function. You are entitled to a **standard** external Grievance review for a grievance not described above. A covered individual may file not more than one (1) external grievance of and insurer's appeal resolution under this chapter.

A covered individual who files an external grievance:

- 1) Shall not be subject to retaliation for exercising the covered individual's right to an external grievance;
- 2) Shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
- 3) Shall be permitted to submit additional information relating to the proposed service throughout the review process; and
- 4) Shall cooperate with the independent review organization by:
 - (a) providing any requested medical information; or
 - (b) authorizing the release of necessary medical information;
 - (c) ICHIA will cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

If You have the right to an external review of a grievance under Medicare, You may not request an external review of the same grievance under this.

To contact the Administrator concerning an appeal or grievance:

Attn: ICHIA / Grievances
P. O. Box 33669
Indianapolis, IN 46203-0669
1.800.552.7921, or
www.ichia.org

GENERAL PROVISIONS:

TIME LIMIT ON CERTAIN DEFENSES: After two years from the issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two year period.

NOTICE OF CLAIM: Notice must be given to Us within 20 days after the occurrence or commencement of any service covered by this Policy, or as soon thereafter as is reasonably possible. You may give the notice or You may have someone do it for You. Notice should include Your name and the Policy number.

CLAIM FORMS: Claim forms are to be used for filing proofs of services. They will be supplied to the person making claim within 15 days of notice of the claim. If claim forms are not supplied within this 15-day period, a claimant may submit proofs of loss as follows:

1. in writing; and,
2. setting forth the occurrence, character and extent of the loss.

PROOF OF CLAIM: Written proof of claims that satisfies Us must be given within 90 days after the date of such claim. However, if it is not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year after the loss occurred, unless the claimant was legally incapacitated.

TIME OF CLAIM PAYMENT: We will pay all claims within 30 days for clean claims filed electronically or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by You or a Provider that has no defect, impropriety or particular circumstance requiring special treatment preventing payment. If a clean claim is not submitted to Us, We will notify You or the Provider within 30 days after the date the claim was filed electronically or 45 days after the date the claim was filed by paper and provide an explanation of any corrective action needed.

PHYSICAL EXAMINATION AND AUTOPSY: We, at Our expense, have the right to have a person examined as often as reasonably necessary while a claim is pending.

LEGAL ACTIONS: No action at law or in equity may be brought to recover under the Policy prior to the expiration of 60 days after written proofs of loss have been furnished to Us as required. No such action shall be brought after the expiration of three years from the time written proofs of loss are required to be furnished to Us unless otherwise permitted by law.

WOMEN'S HEALTH AND CANCER RIGHT ACT: Services for reconstructive surgery following mastectomies are covered by the Plan and include coverage for:

- 1) Reconstruction of the breast on which the mastectomy has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3.) Prosthesis and physical complications of all stages of the mastectomy, including lymphedemas.

UNPAID PREMIUM: In the event a premium is unpaid during the 31 day Grace Period for payment, the claims for dates of service during this period shall be pended and NOT paid. If the premium remains unpaid after 45 days of the due date, all claims for dates of service on and after the due date will be denied.

REFUND OF UNUSED PREMIUM: Unused premium shall be refunded upon the death of an Insured. The amount of premium refund shall be prorated from the date of death to the end of the premium period for which the premium had been paid. The requirements for payments are as follows:

1. If a person other than the Insured paid the premium, the refund will be made to that person.
2. If the Insured paid the premium, it will be paid to the surviving Spouse of the Insured, or if there is no surviving Spouse, the premium shall be paid in the same manner as distribution of the net estate of a person who dies.

A person entitled to receive a refund under these circumstances must do the following:

- a) Submit a written request for refund.
- b) Furnish proof of the Insured's death.

Please allow 30 calendar days from the date of termination request for a refund.

MISSTATEMENTS OF AGE OR SEX: The Premium for this Health Benefit Plan is based on your age and sex and if your age or sex has been misstated, the benefits will be those that the premium paid would have purchased at the correct age or sex.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy in conflict with the laws of the state of Indiana on its Effective Date is hereby amended to the minimum requirements of those laws.

PERIODS OF INSURANCE: All periods of insurance begin and end at 12:01 A.M., Standard Time at Your residence. Your Policy Effective Date is shown on Your Schedule. It ends at 12:01 A.M., on the same Standard Time, on the first Monthly Effective Date, unless otherwise terminated. Each time You renew Your Policy by paying the premium within the 31-day Grace Period, the new term begins when the old term ends.

SUBROGATION: These provisions apply when we pay benefits as a result of injuries or illness You sustained and You have a right to a Recovery or have received a Recovery. We have the right to recover payments We make on your behalf from any party responsible for compensating You for your injuries. The following apply, We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether You are fully compensated and regardless of whether payments You receive make You whole for Your losses and injuries.

You and Your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them. We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by You, Our subrogation claim shall be first satisfied before any part of a recovery is applied to Your claim, Your attorney fees, other expenses paid by Us.

SUBROGATION REIMBURSEMENT: If you obtain a recovery and we have not been repaid for the benefits we paid on Your behalf, We shall have the right to be repaid from the recovery in the amount of benefits paid on Your behalf and the following apply. You must reimburse Us to the extent of benefits We paid on Your behalf from any recovery. Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of recovery in first priority against any recovery. You and Your legal representative must hold in trust for Us the gross recovery (i.e. the total amount of Your recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon receipt of the recovery.

You must reimburse Us in first priority and without any set off or reduction for attorney fees, other expenses or costs. The common fund doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by Us. If You fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of Your recovery, whichever is less, from any future benefits under the Plan if:

1) The amount We paid on Your behalf is not repaid or otherwise recovered by Us or 2) You fail to cooperate. In the event You fail to disclose to Us the amount of Your settlement, We shall be entitled to deduct the amount of Our lien from any future benefits under the Plan. We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of Your settlement, whichever is less, directly from providers to whom We have made payments. In such a circumstance, it may be Your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider. We are entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make You whole.

